

# Coastwide Eye Surgery

## Patient Registration

Erina  
Suite 1:07 Platinum Building  
4 Ilya Avenue  
ERINA 22500

Wyong  
Suite 2 Robley House  
24-26 Hely Street  
WYONG 2259

**Welcome to our Practice.**

**Please fill in the following details and bring this form with you to your appointment.**

## Personal Details

Family Name: \_\_\_\_\_ Mr/Mrs/Ms/Miss/Master/Dr/Other \_\_\_\_\_

Given Names: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postcode

Telephone No: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Medicare No: \_\_\_\_\_ Card No: \_\_\_\_\_ Expiry date: \_\_\_\_\_

Pension No/ Health Care Card No: \_\_\_\_\_ Expiry date: \_\_\_\_\_

Department of Veteran Affairs No: \_\_\_\_\_

Are you privately insured Yes / No (Please circle)

Private Health fund: (Name) \_\_\_\_\_ Membership No: \_\_\_\_\_

## Interested parties

Please list the details of any interested party whom you would like to receive a letter following today's consultation

Referred by: (Name) \_\_\_\_\_ (Phone No) \_\_\_\_\_

(Address) \_\_\_\_\_

Local GP: (Name) \_\_\_\_\_ (Phone No) \_\_\_\_\_

(Address) \_\_\_\_\_

Optometrist: (Name) \_\_\_\_\_ (Phone No) \_\_\_\_\_

(Address) \_\_\_\_\_

Specialist: (Name) \_\_\_\_\_ (Phone No) \_\_\_\_\_

(Address) \_\_\_\_\_

## List of your current medications

\_\_\_\_\_  
\_\_\_\_\_